Off-Unit Transport Documentation

- I-056 Inmate Transfer Roster
- Transport of Offender Form

Transport of Offender

This form will be completed by the Lieutenant on duty each time an offender is transported off unit to include when a unit vehicle is loaned to other units. This form will be turned into the Building Major's Office.

Offender(s) information TDCJ# Name am TDCJ# Name Reason/Cause for Transport Reason: Cause (Injury, Assault, etc.): Scheduled Appointment Emergency Pick-up Other medical emergence Off-Unit Location A Palestine Regional Medical Center Beto Medical HUB UT Health Science Center Hospital Galveston Other: ☐ ETMC Tyler If to a free-word medical facility, follow OMT instructions below! Skyview Unit Mother Frances Hospital OMT Command Center called at 888-456-5556 OMT Command Center Fax Sent/Or Email to HQTN002 Free-World Hospital Contact Person-Title Time Method of Transport Unit Van EMS Transport Officer Information Name Name Rank Rank Name Departure/Return Information Date/Time in Date/Time Out: 0340 NIA 8-13-11 (if returned during same shift) Offender Returned to Unit: Yes No Vehicle Security (Complete this section when transporting by Unit Van) Every transfer vehicle shall be checked for external and internal security before any offenders are loaded on the vehicle. In addition to the routine searches, (i.e. searching for contraband and items that pose a security risk) the following items will be checked. Transfer Officer will initial once completed and prior to departing the unit. All bars and screens over windows as well as between the officer and offender compartments shall be checked to ensure Each Item Completed that none are loose or missing. All security bars, screens, cages and locks are working properly and nothing is loose or missing. The vehicle shall be checked to ensure that it contains a fire extinguisher. nitial when The vehicle tires shall be given a visual inspection including the spare and jack. The 2-way radio shall be checked to ensure that it is operating properly. Offender Search/Restraint Procedures Supervisor and the Transfer Officers will Sign, Print Name and Title Indicating completion of each of the following: Supervisor (Print, Sign, Rank) Transfer Officer (Print, Sign, Rank) The offender will be strip-searched by one (1) of the Transfer Officers under the direct supervision of a security supervisor. Under the direct supervision of a security supervisor, the restraints (leg irons, restraint beit, leg chain, handcuffs and handcuff restraint box) will be placed on the offender by one (1) of the Transfer Officers. The supervisor will check all restraints to ensure the offender is properly secured. The Transfer Officer and security supervisor shall review the transporting offenders' travel card for any security precaution COU designators (escape/assault history) and any other similar criteria IT THEIO relevant to security. Lieutenant's Printed Name/Signature:

PNACOCOTICUM/SJAADES23988

Revision: 10/01/2010

TEXAS DEPARTMENT OF CRIMINAL JUSTICE INSTITUTIONAL DIVISION

INMATE TRANSFER ROSTER

Transferring Unit: Prepare five (5) copies of this roster for each unit that is to receive men. Send original and duplicate with men being transferred. Triplicate: Attach to your daily strength report and mail to W.H. Gaston, Director, Personnel Records. Quadruplicate: Attach to your file copy of the daily strength report. Fifth copy: Inmate record section.

Receiving Unit: You must receive two copies of this form with each group of men transferred to your Unit. Original attach to your daily strength report.

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UTMB Correctional Managed Care Report

- Facility Death Review for Total Quality Management
 - o Attachments

This Information is privileged and confidential and is prepared and distributed in accordance with Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161 032 and 161 033

Final UTMB CORRECTIONAL MANAGED CARE FACILITY DEATH REVIEW FOR TOTAL QUALITY MANAGEMENT (TQM)

PATIENT NAME:

Kenneth W. James

TDCJ-ID#:

1726849

DATE OF BIRTH:

11/25/1958

AGE: 52

DATE OF INCARCERATION: 8/10/2011

DATE RECEIVED ON UNIT

8/10/2011

DATE AND TIME OF DEATH: 8/13/2011 @ 04:16 by Dr. Heidi Knowles @ PRMC

FACILITY: Gurney

Documentation Reviewed (check all appropriate boxes):

TDCJ / UTMB	Medical Records	х	Physician's Death Summary	Other:	
Community H	ospital Records	х	Preliminary Autopsy Report		
Video Tape			Final Autopsy Report		

Persons Interviewed / Title:

- 1. D. Washington LVN
- 2. D. Rinehart LVN
- 3. S. Smith PA
- 4. P. Rayford Major

5.

Administrative Check List:

	Date Completed:
Death Notice to TDCJ Divisional Director of Health Services within 72 hours	8/13/2011
Custodial Death Report to UTMB Death Record Technician within 10 days	
Death Summary completed within 30 days	
Death Certificate completed and signed	
Complete Medical Record to Death Record Technician within 30 days	4

PATIENT CASE SUMMARY (may attach Death Summary for items covered in that document):

Current Diagnoses: cardiac arrest

Current Medications:

Vasotec 10 mg - 1 tab bid Hydrodiuril 25 mg - 1 tab q day Inderal 10 mg - 1 tab bid

Relevant Medical History: HTN, Lumbar Laminectomy x 2, Bilateral Inquinal Hernia Repair

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Summary of Events on the Day of Death:

- 02:40 Officer Glorie Harris CO IV notified LT. Whitfield that Offend James was urinating on himself and was ill
- 0243 Officer Torrance Stephens CO V and Kenneth Mangan CO IV respond with wheelchair and transport Offender James to the Unit Medical Department
- 0245 RN McKnight at the Beto Unit was notified by Sergeant Tully Flowers of Offender James situation. RN McKnight advised to transport Offender James to Beto for evaluation
- 02:47 Offender blood pressure taken by security 89/57, T 108
- 0248 Lt. Whitfield is notified of the offender's condition and he notifies central control to call 911 for emergency services
- 0250 RN McKnight is advised that Lt. Whitfield has called 911 to respond.
- 0251 Lt Whitfield arrives at the medical department and he advises Sergeant Seda to move the offender into the emergency room and place on gurney. Lt. Whitfield checks for a pulse and feels one.
- 0318 EMS arrives at back gate
- 0319 EMS ambulance arrives at the back door of medical department.
- 0320 Lt Whitfield briefs paramedics on offender's condition.
- 0323 Lt Whitfield receives a phone call from the 911 operator (Sarah Wardell) informing him an air ambulance was en-route.
- 0327 Offender transferred to EMS gurney
- 0328 Offender James was moved from the emergency room to the back door of the medical department and placed in the ambulance.
- 0330 Paramedics request assistance from an Officer McKnight to assist with life saving measures.
- 0338 Ems departs unit en-route to PRMC with code in progress
- 0416 Dr. Heidi Knowles M.D. pronounced Offender James deceased
- NOTE: *** ETMC helicopter was 5 minutes out from Gurney but did not transport Offender James due to code in progress****

Summary of Nursing Actions / Events prior to Death:

8/10/2011 - Pt received @ back door from county - c/o pain lower back, r- leg

8/12/2011 – 11:45 - Pt seen in medical for Intake physical exam by S. Smith PA v/s: BP 170/107, Wt. 254, H 71 in, P 108, R 18, T 96.7

Ordered: chest x-ray, lab, and EKG

Restrictions: III – 11,12,14

Case 4:14-cv-03253 Document 303-5 Filed on 09/08/16 in TXSD Page 7 of 53

This Information is privileged and confidential and is prepared and distributed in accordance with Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161.032 and 161.033.

CCC HTN in 30 days BP checks x 7 days

11:55 - D Rinehart LVN rec'd verbal order from S Smith PA for Clonidine 0.2 mg now 0.2 mg Clonidine Administered – BP 170/100, P 108

12:30 - recheck blood pressure 129/74, P 100 - pt returned to provider to complete intake physical

17:40 to 18:00 approx. – D. Washington LVN received call from B Dorm (Officer Debra Gilmore) about Offender Kenneth James # 1726849. Mr. Washington LVN states he was informed Offender James was complaining of being dizzy. Mr. Washington states he informed Officer Gilmore to have Offender James drink water, stay as cool as possible, and if they thought Offender James needed to come to medical to have him come down.

19:00 - Clinic closed for the day - Offender James had not reported to medical

Critic 1.	al Nursing Care Issues: Was CPR initiated and maintained Yes If CPR was not initiated, Explain:	until assume No	d by EMS <i>or</i> p x Not Applic		onounced dead [*]	?
2.	Did Nursing notify the Provider? If No, Explain:	Yes	☐ No	x Not Applic	able	
3.	Did Nursing function appropriately Yes If No, Explain:	during the e	mergent phase x Not Applica			
4.	Did Nursing determine any educational opportunities 1. Remedial education for nursing	es:				k No erning
patien	ts 2. 3. 4.					
5.	Did Nursing determine any correct <i>Identified Corrective Action Need(s</i> 1. LVN D. Washington – retake the 2. RN McKnight – In-service by Nur 3.	s): Protocol Impl	ementation CI		X Yes No	

Case 4:14-cv-03253 Document 303-5 Filed on 09/08/16 in TXSD Page 8 of 53

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Significant Findings and/or Areas of Concer	n (not addressed in nursing	section):
Possible heat related incident		
Corrective Action(s) Implemented:		
 LVN D. Washington – required to enroll RN McKnight – required to complete 		
Committee Members Present at Facility TQM	Meeting:	
Name	Title	Date
Name	Title	Date
Name	Title	Date

Case 4:14-cv-03253 Document 303-5 Filed on 09/08/16 in TXSD Page 9 of 53

This Information is privileged and confidential and is prepared and distributed in accordance with

Name	Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161 032 and 161 033 Title	Date
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This Information is privileged and confidential and is prepared and distributed in accordance with Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161.032 and 161.033.

Summary of Events on the Day of Death:

02:40 – Officer Glorie Harris CO IV notified LT. Whitfield that Offend James was urinating on himself and was ill

0243 – Officer Torrance Stephens CO V and Kenneth Mangan CO IV respond with wheelchair and transport Offender James to the Unit Medical Department

0245 – RN McKnight at the Beto Unit was notified by Sergeant Tully Flowers of Offender James situation. RN McKnight advised to transport Offender James to Beto for evaluation

02:47 - Offender blood pressure taken by security 89/57, T 108

0248 - Lt. Whitfield is notified of the offender's condition and he notifies central control to call 911 for emergency services

0250 - RN McKnight is advised that Lt. Whitfield has called 911 to respond.

0251 – Lt Whitfield arrives at the medical department and he advises Sergeant Seda to move the offender into the emergency room and place on gurney. Lt. Whitfield checks for a pulse and feels one.

0318 - Ems arrives at back gate

0319 – EMS ambulance arrives at the back door of medical department.

0320 - Lt Whitfield briefs paramedics on offender's condition.

0323 – Lt Whitfield receives a phone call from the 911 operator (Sarah Wardell) informing him an air ambulance was en-route.

0327 Offender transferred to EMS gurney

0328 – Offender James was moved from the emergency room to the back door of the medical department and placed in the ambulance.

0330 - Paramedics request assistance from an Officer McKnight to assist with life saving measures.

0338 - Ems departs unit en-route to PRMC with code in progress

0416 - Dr. Heidi Knowles M.D. pronounced Offender James deceased

NOTE: *** ETMC helicopter was 5 minutes out from Gurney but did not transport Offender James due to code in progress****

Summary of Nursing Actions / Events prior to Death:

8/10/2011 - Pt received @ back door from county - c/o pain lower back, r- leg

8/12/2011 – 11:45 - Pt seen in medical for Intake physical exam by S. Smith PA v/s: BP 170/107, Wt. 254, H 71 in, P 108, R 18, T 96.7

Ordered: chest x-ray, lab, and EKG

Restrictions: III – 11,12,14

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CCC HTN in 30 days BP checks x 7 days

11:55 - D Rinehart LVN rec'd verbal order from S Smith PA for Clonidine 0.2 mg now 0.2 mg Clonidine Administered – BP 170/100, P 108

12:30 - recheck blood pressure 129/74, P 100 - pt returned to provider to complete intake physical

17:40 to 18:00 approx. – D. Washington LVN received call from B Dorm (Officer Debra Gilmore) about Offender Kenneth James # 1726849. Mr. Washington LVN states he was informed Offender James was complaining of being dizzy. Mr. Washington states he informed Officer Gilmore to have Offender James drink water, stay as cool as possible, and if they thought Offender James needed to come to medical to have him come down.

19:00 - Clinic closed for the day - Offender James had not reported to medical

Critica 1.	al Nursing Care Issues: Was CPR initiated and maintained until assumed by EMS <i>or</i> patient was pronounced dead? Yes No x Not Applicable If CPR was not initiated, Explain:
2.	Did Nursing notify the Provider?
3.	Did Nursing function appropriately during the emergent phase? Yes No x Not Applicable If No, Explain:
4.	Did Nursing determine any educational opportunities related to this event? Yes x No Identified Educational Opportunities: 1. 2. 3. 4.
5	Did Nursing determine any corrective action need(s)? Identified Corrective Action Need(s): 1. 2. 3.

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This Information is privileged and confidential and is prepared and distributed in accordance with Vernon's Annotated Civil Statutes, Health and Safety Code, Chapter 161.032 and 161.033. Medical Staff Present During Terminal Event (if death occurred on a TDCJ facility): 1. None 2. 3. 4. 5. 6. Autopsy Findings (or attach autopsy report, enter N/A if autopsy not ordered, enter Pending if ordered but not received at time of review): pending Significant Findings and/or Areas of Concern (not addressed in nursing section): Possible heat related incident Corrective Action(s) Implemented: None Committee Members Present at Facility TQM Meeting: Title Date Name Title Date Name

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Date

Date

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Name	Title	Date
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Name	Title	Date

Interoffice-Correspondence
Danny Washington LVN
08-17-11

This Interoffice Correspondence is in regards to Kenneth James, TDC # 1726849. On or about 08-12-11, at approximately 1800 hours, I received a call from the B-dorm in regards to Kenneth James. The officer stated that they had an inmate that was dizzy. I advised him to have the patient to drink water, stay as cool as possible, and if they thought that he, the patient needed to come down, to have him come down. By the time that we left the clinic at the end of the shift, I had not seen this patient.

When we arrived the following day, Security advised us that the patient had passed away during the night.

Danny Washington LVN